12/13/17 Ltr Acceptable

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES 45th 01/14/18/70th 02/08/18

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445132	A. BUILDING _____ B. WING _____	11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVIERVILLE HEALTH AND REHABILITATION CENTER	415 CATLETT RD SEVIERVILLE, TN 37862

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey was conducted on 11/28/17 through 11/30/17 at Sevierville Health and Rehabilitation Center. The facility was found to not be in substantial compliance with the regulations at 42 CFR 483, Requirements for Long term Care Facilities.	F 000	**Disclaimer** **Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.** It is the policy of Sevierville Health and Rehabilitation Center not to leave medications with residents to self-administer unless the resident is approved for self-administration of the medication. Resident #4 was assessed by the Director of Nursing on 11/29/17, no ill effects were noted. Medications observed left with this resident on 11/29/17 at 8:39 am were then properly administered by Nurse #1 and observed to be taken by the resident on 11/29/17. All other residents on Nurse #1 assignment on 11/29/17 were assessed by the Director of Nursing to assure no medications had been left at bedside, and none were observed at bedside. Interview with Nurse #1 on 11/29/17 by Director of Nursing revealed that Resident #4 requests at times for her medications to be left at bedside. Interview also revealed that Nurse #1 was aware that this action was not an acceptable procedure and did not follow facility policy.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to assess 1 resident (#4) of 7 residents reviewed for self-administration of medications. The findings included: Review of facility policy "Medication Administration" dated 3/16/15 revealed "...prepare medications immediately prior to administration...observe that the resident swallows oral drugs...do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication..." Medical record review revealed Resident #4 was admitted to the facility on 1/1/00 and readmitted on 6/2/17 with diagnoses including Unspecified Heart Failure, Type 2 Diabetes Mellitus, Anxiety, Other Recurrent Depressive Disorders, Essential Hypertension, End Stage Renal Disease, Muscle	F 554		12/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Hansard | TITLE: Administrator | (X6) DATE: 12/13/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 Weakness, and Unspecified Cirrhosis of Liver. Medical record review of Resident #4's Quarterly Minimum Data Set (MDS) dated 9/6/17 revealed the resident scored 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Observation and interview with Licensed Practical Nurse (LPN) #1 on 11/28/17 at 8:39 AM, in the resident's private room, revealed Resident #4 was alone in her room and a medication cup containing 8 pills was sitting on the resident's bedside table. Interview with LPN #1 revealed the medication cup contained the following medications: *two 500 microgram (mcg) Cyanocobalamin tablets (medication to treat vitamin B-12 deficiency) *one 80 milligram (mg) Furosemide tablet (medication to treat fluid retention, edema, and swelling) *two 2,000 unit Vitamin D3 tablets (supplement to improve overall health or for treating osteoporosis) *one 1,000 unit Vitamin D3 tablet *one 5 mg Biotin capsule (Vitamin B supplement) *one 800 mg Renvela tablet (medication to control phosphorus levels in people with chronic kidney disease) Continued Interview with LPN #1 confirmed no assessment for self-administration of medications had been completed. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 11/30/17 at 9:15 AM, in the Nursing Office, confirmed Resident #4 was assessed for self-administration of medications and the facility	F 554	Nurse #1 was terminated from employment by the Director of Nursing on 12/1/17 for failure to follow facility policy by knowingly leaving medications at the beside of a resident who had not been assessed to self-administer her own medication. All licensed nurses on duty 11/29/17 were re-educated by the Staff Development Coordinator regarding facility policy on Medication Administration as related to leaving medications at bedside (see attachment 554a). All licensed nurses employed by the facility were re-educated by the Staff Development Coordinator or Director of Nursing 12/8/17 - 12/12/17 on facility Medication Administration as it relates to leaving medications at beside (see attachment 554b). The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or RN Supervisors will audit resident medications at bedside to assure this is not occurring without an approved self-assessment being in place. Audit rounds in 100% of resident rooms will be made daily for 1 week or until 100% compliance is reached, then 3x a week for 3 weeks in 50% of resident rooms or until 100% compliance is reached, then 1x a week for 2 months in 25% of resident rooms or until 100% compliance is reached. Another audit 1 month later will be made of 100% of resident rooms and if 100% compliant it will be concluded that the problem has successfully been addressed (attachment 554c audit tool)	

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F 554	Continued From page 2 failed to follow facility policy.	F 554	Audit results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement Committee meetings for review and recommendations. This Committee will determine if any revisions are needed to the action plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Staff Development Coordinator, Human Resources, MDS Coordinator, Business Office Manager, Rehab Manager, Medical Records Director, Social Services Director, Maintenance Director, Housekeeping Director, Dietary Manager and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to obtain and record temperatures in the ice cream freezer, milk cooler, and the reach-in cooler and failed to maintain dietary equipment in a sanitary manner, in 1 of 3 kitchen observations made, affecting 75 of 75 residents in the facility. The findings included: Review of the facility policy, Record of Refrigeration Temperatures, revised 7/2014, revealed "...A daily temperature record is to be	F812	It is the policy of Sevierville Health and Rehabilitation Center to obtain daily temperature records on refrigerated items, to maintain the sanitation of the can opener after each meal or more frequently as needed, and to maintain a clean interior of the convection oven. Temperature logs for the ice cream freezer, milk cooler and reach-in cooler were posted for use and initiated on 11/28/17 by the Dietary Manager. The can opener was cleaned on 11/29/17 by the Dietary Manager.	12/30/17

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F 812	Continued From page 3 kept of refrigerated items...Record temperatures from the internal thermometers..." Review of the facility policy, Dietary Department Guidelines, not dated, revealed "...The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness...Refrigerator temperatures will be monitored regularly, and logs will be maintained of all temperatures..." Review of the facility policy, Cleaning Schedules, revised 3/2014, revealed "...The Dietary staff shall maintain the sanitation of the Dietary Department..." Review of the facility policy, Can Opener, revised 9/2011, revealed "...Sanitation of equipment...after each meal; more frequently if needed...Scrub the shank, paying special attention to blade..." Observation and interview with the CDM on 11/28/17 at 10:15 AM, in the kitchen, revealed no documentation temperatures had been obtained or recorded for the ice cream freezer, milk cooler, or reach-in cooler. Interview with the CDM confirmed the facility failed to obtain and record temperatures for the ice cream freezer, milk cooler and reach-in cooler, and the temperature logs were not maintained. Observation with the CDM on 11/29/17 at 9:30 AM, in the kitchen, revealed a can opener with dried thick debris on the blade. Further observation revealed the convection oven had dried burnt debris on the interior bottom and on the interior doors of the oven.	F 812	The interior bottom and interior doors of the convection oven were cleaned on 11/29/17 by Dietary staff. Existing posted temperature logs were reviewed by the Dietary Manager on 11/28/17 to assure daily temperature records were being recorded, and no discrepancies were found. Existing posted cleaning schedules were reviewed by Dietary manager on 11/29/17 to assure the can opener and the convection oven were included per policy, and both were scheduled for cleaning per policy. All Dietary staff were re-inserviced by the Dietary Manager on facility policies Record of Refrigeration Temperatures and Cleaning Schedules related to Convection Oven and Can Opener 12/1/17- 12/11/17 (see attachment 812a). The Dietary Manager will audit temperature logs on the ice-cream freezer, milk cooler and reach in cooler to assure daily temperatures are being recorded per policy. The Dietary Manager will audit the cleanliness of the can opener and convection oven to assure cleaning is being completed and documented on posted cleaning logs per policy. Audits will be made daily for 1 week or until 100% compliance is reached, then 3x a week for 3 weeks or until 100% compliance is reached, then 1x a week for 2 months or until 100% compliance is reached. Another audit 1 month later will be made and if 100% compliant it will be concluded that the problem has successfully been addressed. (see attachment 812b).	

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F 812	Continued From page 4 Interview with the CDM on 11/29/17 at 9:35 AM, in the kitchen, confirmed the facility failed to maintain dietary equipment in a clean and sanitary manner.	F 812	Audit results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement Committee meetings for review and recommendations. This Committee will determine if any revisions are needed to the action plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Staff Development Coordinator, Human Resources, MDS Coordinator, Business Office Manager, Rehab Manager, Medical Records Director, Social Services Director, Maintenance Director, Housekeeping Director, Dietary Manager and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	